

This is the peer reviewed version of the following article: Marrable, Tish (2014) Emotion in responses to the child with ‘additional needs’ *Child and Family Social Work* 19(4) pp 401–410 ISSN 1365-2206, which has been published in final form at DOI: 10.1111/cfs.12035. This article may be used for non-commercial purposes in accordance with [Wiley Terms and Conditions for Self-Archiving](#).

## Emotion in responses to the child with ‘additional needs’

### ABSTRACT

The work that is done with children and young people by the practitioners of health, education, or social care forms part of their experience of growing-up, and for some children can have a profound impact on their future outcomes. Children may find themselves ‘impotent at the hands of powerful others’ (Wearmouth, 1999: 19) particularly where their behaviour causes concern. This paper reports on a key theme from the author’s doctoral research into the ways the emotion-laden interactions between practitioners in multi-agency children’s services, child, and parent, affected the diagnosis, treatment, communication, and outcomes for children’s wellbeing defined within Every Child Matters (Department for Education and Schools, 2004). Exploring the emotion within interactions permits a different perspective on ‘need’, and the paper argues finally for more careful, emotionally reflective practice from those who work with children.

Keywords: emotion, multi-agency working, additional needs, depth processes, inclusion

### INTRODUCTION

The work that is done with children and young people by the practitioners of health, education, or social care forms part of their experience of growing-up, and for some children can have a profound impact on their future outcomes. Children may find themselves ‘impotent at the hands of powerful others’ (Wearmouth, 1999: 19) particularly where their behaviour causes concern; they are admonished or encouraged, labelled and diagnosed, decisions are made on their behalf or their need for support is rejected. The availability of resources may alter the thresholds for support (Brandon *et al.*, 2008; Turney *et al.*, 2011) leaving some children to cope with everyday life in their own ways, or not to cope at all. This paper reports the findings from the author’s doctoral research into the ways children become defined as having ‘additional needs’ and how adult perceptions and definitions of the child influence the actions taken with them (Marrable, 2011). It focuses on a key theme which linked the diverse cases within the research: the emotion-laden interactions between practitioner, child, and parent, and the ways that this often pained and stressful emotion affected the diagnosis, treatment, communication, and the outcomes for the child’s wellbeing, defined first within Every Child Matters (Department for Education and Schools, 2004). Exploring these permits a

different perspective on ‘need’, and the paper argues for a more emotionally reflective practice from all those who work with children.

## CHILDREN AND ‘ADDITIONAL NEEDS’

The category ‘children with additional needs’ emerged out of the *Every Child Matters* (ECM) policy agenda. This initiative was launched in 2003 in England as part of a rolling programme for improving services for children (Department for Education and Skills, 2003), coinciding with the Laming Report into the tragic case of young Victoria Climbié (Lord Laming, 2003). Her untimely death, despite professionals from health, education, and social welfare being aware of her vulnerability, was perceived as a failure of the disconnected and bureaucratic practice of the various bodies of practitioners whose purpose is to protect children. Many such cases have arisen over the years, and Brandon *et al* (2008) found in their survey of 161 Serious Case Reviews (from 2003 to 2005) that the gaps in multi-agency practice identified in the Climbié case can be seen again in these reviews. ECM’s goal – the provision of a joined-up service with common aims and values, where professionals communicate with each other as well as working together in an integrated manner – was intended as a step towards closing these gaps. The aim of preventing children’s problems or at least instigating early intervention before problems became entrenched (Department for Education and Skills, 2003, 2004) provided the impetus for a new category of ‘need’ to come into official use – additional need, or more accurately, *children with additional needs* since the term, in this context, was only used in conjunction with the child.

ECM defined children with additional needs in its glossary (Department for Education and Skills, 2006) and its overview of the systems for recording need (Department of Children Schools and Families, 2007), as *any* children whose need for support goes beyond that which is provided by education and general health services to all children. It was anticipated that between 20% and 30% of children would fall into this category at some point, although this might be a temporary positioning. Children with *complex needs*, who might receive specialist or statutory services, are still part of this group, just as all children, no matter what their needs for help or support, are entitled to universal services (Figure 1).

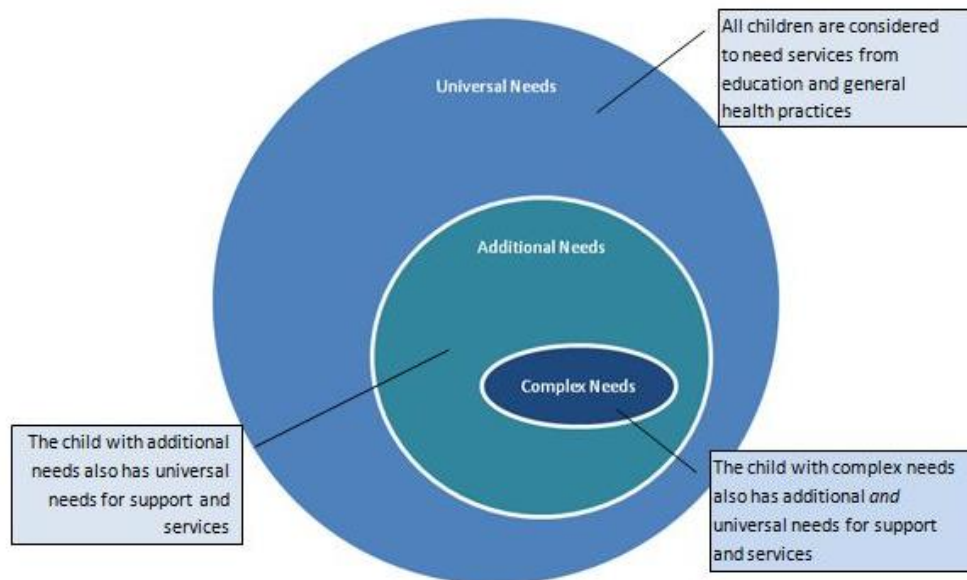


Figure 1: The inter-relational nature of levels of 'need'

*Children in need*, as defined within Section 17 of the Children Act 1989 (HM Government, 1989) are also included within additional need's broad definition (Department for Education and Skills, 2006). Axford (2010) argues that there is a tension between the categories; the 'child in need' looks to minimise harm already evident or clearly threatened, while 'additional need' implies maximising inclusion. While the categorisation and ranking of children's behaviour or development in relation to 'need' is in any case contested, as it implies a 'normal' child that others can be measured against (Billington, 2000; Rose, 1999; Taylor, 2004; Woodhead, 1997), within restrictive resources and high thresholds for services a non-labelling approach can leave a child with no help. This dilemma was expressed clearly by professionals from health in the study; as one psychiatrist said, "You could spend all your time *not* doing something, and sometimes doing *something* is better".

There is much to admire in ECM's inclusive aims and approach. However, implementing the plan, improving the well-being of children and young people in line with the five outcomes of the Children Act (2004), proved problematic. The Audit Commission report, *Are we there yet?*, stated that: '[f]ive years after the Laming Inquiry, there is little evidence that Children's Trusts have improved outcomes for children' (Audit Commission, 2008:4). Findings were that while progress had been made towards implementing the new bureaucratic processes, less progress could be seen in tangible improvements for children and families. This may signify that the approach is still too 'surface' (Cooper & Lousada, 2005; Howe, 1996), focussing on procedures rather than the deeper, more complicated business of human social relationships (see also Reder & Duncan, 2003; 2004 re. these concerns). Practitioners in children's services work in complicated, busy situations, and have to make decisions daily about who should or should not receive help, and what types of help are necessary. These decisions may be assisted by the processes put in place under

ECM such as the Common Assessment Framework (CAF), but are also shaped by a multiplicity of personal, interpersonal, institutional, societal and cultural influences. Children, young people and their families have a similar array of influences within their lives as well as being set within an intersectional tapestry of social class, gender, age, education and ethnicity. This complex overlapping of factors creates a facade which can make it difficult to understand the underlying processes which shape definitions of, and decisions about, the child (Marrable, 2011). Cooper and Lousada (2005) argue that the less conscious processes, ‘depth phenomena’, may be more difficult to explore than those at the surface because of the messy, potentially ambiguous nature of personal and social worlds:

We do not think that the “depth phenomena” are more real than their “surface” counterparts, but we do hold that surfaces can obscure, and may be intentionally, as well as consciously and unconsciously designed to do so. A view of personal and social phenomena as multi-layered and thus susceptible to more than one account of their nature raises very contemporary questions about where, if anywhere, reality is to be found. (Cooper & Lousada, 2005:19)

The view that we are still only “kind of plastering the cracks” as an education professional in the study put it – both the cracks that children’s problems cause in their lives, and the cracks in attempts to work cohesively and inclusively with those children – is reinforced by Brandon *et al*’s analysis of 161 serious case reviews for the period 2003-2005 (2008). Their study showed that 45% of these cases were invisible to children’s social care when the incident took place, receiving either universal services only or at the level of additional need. Successful interventions depend not only on children’s problems being identified and the wherewithal for support being available, but also on the practitioners’ ability to go beneath the surface to deal with that which has been obscured: within their own processes, and within the child’s need for support.

## THE RESEARCH AND CASE STUDY

This paper arises from the author’s doctoral research which explored the construction of the child with additional needs within children’s services. It examined the role of definition in inclusive practice, asking:

- How do children become defined as having additional needs?
- Whose interests are served by this process of definition?
- What are the implications of an understanding of these processes for service provision to children with additional needs?

This qualitative study used a multiple case design set within the boundaries of a large secondary school. It took a ‘child outwards’ approach, moving from the child and their views to the multi-agency field of practitioners working with each child and their families. With agencies from health, social care and education taking part, ethical approval was gained through the NHS Research Ethics Committee, the local authority, and the school itself. Informed consent was received from all participants in the study. The twelve child participants from a single year group (year 7, ages 11-12)

were selected initially to reflect a broad range of support needs based on information from the school, as well as the willingness of the children and their parents to take part. The gender ratio in the group was 2 boys to each girl, similar in proportion to the school's registers of additional need.

Data collection took place through observations of child-adult interactions in practice and home, with the researcher placed as 'observer-as-participant' (Gold, 1958), semi-structured interviews with children and adults, and analysis of formal records for the child. A symbolic interactionist approach (Blumer, 1969) provided the basis for a psychosocial analysis of the data, looking for the similarities and differences between these diverse cases. Blumer suggested that within symbolic interactionism, analysis should be what he termed 'inspection', a 'careful, flexible scrutiny' of the data: 'inspection is flexible, imaginative, creative, and free to take new directions' (Blumer, 1969: 44). Taking this as a position, data were analysed using a constructivist grounded approach (see Charmaz, 2000), utilising NVivo qualitative data analysis software to systematically facilitate this iterative inspection of the data, allowing the emergence of themes and concepts through a deep engagement with the data. The findings and arguments presented here are based on the data from the twelve children and their interactions with parents, social workers, education workers, members of a youth offending team, child and adolescent mental health services (CAMHS), and other health professionals.

The dominant themes from the overall analysis will be illustrated through one case. Martin (not his real name) was not one of the most 'difficult' of the children in the study. To try and choose a 'typical' case to represent 'additional need' would not respect the complexity recognised here, but Martin's 'manageability' make the emotion-driven responses demonstrated through his case resonate more notably than if he was one of the children whom teachers called "high tariff". He had a long standing diagnosis of attention deficit hyperactivity disorder (ADHD) and took medication intended to help him control the angry outbursts which troubled him. Other medication helped him sleep. His family were not known to social services. The school labelled him on the special educational need register as 'BESD' (behavioural, emotional and social difficulties), with a note of the diagnosis of ADHD. He was viewed as manageable by the school; not problematic enough to have drawn their attention if his mother hadn't contacted them to tell them how unhappy he was:

*If she hadn't done that I don't think anything would have happened for him, if I'm honest, I'm not happy about that, but that's the reality (Special Educational Needs Co-Ordinator - SENCO).*

Looking at this one case opens up a window to all the others. As in the intricate fractal representations that illustrate chaos theory, one small area can be as rich, fascinating and illuminating as the whole picture.

## MARTIN DEFINED THROUGH DIAGNOSIS

Highly trained professionals – medical doctors including psychiatrists, or psychologists, for instance – diagnose difference or dysfunction as a category or disorder, as a way of clarifying and simplifying the complex and multilayered nature of social, physical, and emotional needs. The purpose is to prescribe suitable treatment to bring the child back into ‘normal’ parameters of, for example, behaviour, health, or learning ability. Professional ‘tools’ are used within this to promote accuracy and regularity: medical tests for physical illnesses or disability, the Diagnostic Statistical Manual (DSM, American Psychiatric Association, 2000) and psychological questionnaires and surveys for those considered to have difficulties in the emotional, learning or behavioural spheres. Diagnosis often involves a label of ‘need’ which can be used in conjunction with the child to signify the focussed problem, so that the child becomes the ‘child with ADHD’, the ‘dyslexic child’ or the ‘child with epilepsy’.

However the diagnostic process is not clear cut. Some of the classic criticisms of psychiatric practice apply here: terms that are subjective and rely on professional interpretation, broad categories which provide a catch-all for troublesome people, and political issues such as pharmaceutical companies’ power in shaping what constitutes normality and abnormality (Timimi, 2005). White & Featherstone (2005) point to the ambiguities in diagnosis related to differing discourses in multi-professional talk. Diagnosis is also made in the lay world to explain behaviours that are considered abnormal, by parents or teachers for instance.

Also culpable in diagnosis are feeling and emotion. Denzin (1984) points out that in studies of emotion emphasis is more often placed on ‘negative’ emotion such as anger, anxiety, or fear, rather than ‘positive’ emotions such as love, joy, or trust. While this may seem inevitable within the often stressful circumstances in which children come to the attention of adults, Martin’s case demonstrates how these ‘negative’ emotions can be combined with empathy, both for the individual and the situation. However, these combinations may have a different impact on the decisions that follow, for instance, anxiety and empathy can produce a feeling of helplessness for the professional. This is illustrated here by the CAMHS psychiatrist who had diagnosed Martin as having ADHD. In the following extract she tried to pinpoint how he came to be one of her clients, reading from old case file notes as she spoke:

*he was three when he! three and a half, no so he was three and a half, no so he’s..he’s been with us forever, bless him, and the family had reached a crisis point. Mum had to be dragged away from Martin by her husband as she was going to harm him and she was terrified... she made clear she’s terrified by her behaviour, she said she’d been capable of harming him and lost all control, she was horrified that she could have got to such a pitch and was asking for help.*

Her surprise that he had been with CAMHS “forever”, and her sympathy for him – “bless him” – was also indicative of the helplessness she felt in the face of his mother’s emotions. This issue of losing control – becoming lost in the uncomfortable moment of what the pragmatist William James termed a ‘coarser’ emotion (1890 cited in Denzin 1984) – was one that came up repeatedly in Martin’s own talk about his experience of ‘ADHD’, for instance: “I’ve got to take tablets to make me feel better, otherwise I just lose control”.

Although Martin has been defined for most of his life as ‘having ADHD’, the psychiatrist was highly ambivalent about whether this was even the correct diagnosis for him. She felt that perhaps the problems with his behaviour clustered around a combination of some developmental problems, difficulties with ‘attachment’ in the family, and the ways that his mother’s depression “perhaps had impacted on her...bonding and relationship with Martin”.

Martin’s father played a less obvious role in talk about Martin’s problems. Although he was spoken of briefly, it was hesitantly, related to Martin’s mother rather than Martin and allowing the discussion to shift back mother-wise. However, clearly his own ‘out of control’ emotions had been exhibited when early on he attended some family therapy sessions:

*I think he supports mum a bit more than he used to, but certainly there was a long place when he would just...he would come in and get very...angry... I think she sort of ...almost wanted him to back off because he got too angry too quickly, but then she was quite exhausted dealing with... Martin, I think he was quite difficult, quite... challenging. She was very keen to try umm... some medication...*

Martin’s father did not take part in the study so could not share his story of Martin’s ‘need’. His anger and frustration may have been with professional systems, or because he disagreed with the medicalised route for his son. It may be that he was angry because he found Martin difficult, or because he was helpless in the face of a very determined and depressed mum, who was also losing her temper with Martin. However his temper is never linked to Martin’s own temper, which Martin himself feels is his real problem.

The psychiatrist expressed her own sense of helplessness – trying to do her best – in the face of his mother’s ‘desperate need’:

*I’m going to be honest about Martin, he’s one of these kids who, and so many of them I see are like this, who doesn’t neatly fit into any one box either, so he is Martin, he’s himself, he’s an individual, and if you go and fit him into a box - when he was younger certainly the ADHD one. And I think this is a case where... her desperate need for some medication for Martin has swayed what I... in another family Martin’s behaviour might have been managed differently and he might not have needed medication. Umm, but I think you have to be quite responsive to the needs of the family as a whole, because without giving him the medication she probably would have murdered him!*

*[both laugh]. It did seem to help and, mum, I think it's, you know my impression is that...as a person he's ...doing quite well, I know he hates school but I think he's one of these vulnerable... children that, ummm, big secondary schools don't...aren't always suited to.*

Although she admitted here that she felt her actions with Martin were more to do with his mother than him, expressing both helplessness and frustration, she diffused the mood of the first part of her statement with her comment that medicating Martin has stopped his mother murdering him (intended humorously as we laugh but evoking her anxiety that this might be true). In the end, 'doing quite well' was seen as good enough for Martin. Hating school, not functioning well in the large school system, is par for the course for "vulnerable children that big secondary schools don't...aren't always suited to", and not something that she can do anything about in her professional role.

The psychiatrist's unwillingness to speak with Martin's mother directly about her 'real' diagnosis of attachment disorder might be part of what she described earlier as being "sensitive" to parent's needs, but might also arise from fear and anxiety in the face of a well-spoken, well-informed, determined and distressed parent. However this rebounded in the mother's own interpretation of their meetings. As the psychiatrist danced around the issue of diagnosis, Martin's mother interpreted this as a form of professional control – "that's what their role is and that's what they'll do" – and a way of pushing her 'lay' concerns aside:

*She used to say to me there wasn't much of a problem and I actually said to her one day, if there isn't much of a problem, why is he on medication? And she didn't answer me, she squirmed in her seat and she said, well we know that there is a little bit of a problem, but . . . And I'm like, but where was my answer? And then she went off at some tangent and I'm thinking hang on a minute, she hasn't answered my question! And out he goes to be weighed, to have his blood pressure taken and just basically see how things are, and I've resigned myself to that's what their role is and that's what they'll do.*

Her angry description of the psychiatrist 'squirming', and then belittling her concerns as 'a little bit of a problem' were counteracted by her logic (based however in a tenuous diagnosis) that if Martin is on medication, there must be a real, medical problem with Martin. The psychiatrist might have appeared to squirm because she was uncomfortable with her diagnosis, but seemed unable, in her anxiety, to assert her professional authority so that Martin's help might be properly directed.

## CREATING DIVISION

The interactions between child, parent, and professional are inevitably a setting for shifting emotion. Foucault describes power as set in the micro-capillaries of the social body (1994), which suggests that the level of interaction is very important for power relations (Atkinson & Housley, 2003). However does not imply that all power



relationships are equal: '[t]o live in society is, in any event, to live in such a way that some can act on the actions of others.' (Foucault, 1994: 343).

The power of diagnosis is part of what Foucault termed 'dividing practices' (Foucault, 1994), which can be described as the technologies of creating difference, or 'othering' people. Diagnosis through the DSM, which critically in every new version catalogues a wider range of behaviours or states of mind considered abnormal, is used as an authoritative voice for defining the child. Although its accuracy or relevance is contested (Rose, 2007), it carries the weight of control. A DSM diagnostic label, lodged in normalisation practices aimed at producing a picture for professionals to measure against (Chambon, 1999: 66) may not provide anything useful for a different sort of practitioner to work with. Instead it may create a sense of unease and disjuncture between the label and personal opinion. The head of Martin's year at school described him as "not a huge behavioural problem" although she wavered between suggesting that he "kicks off" and, a different sort of description, "he acts very much like a very silly little boy". Although she described herself twice as "not an expert", she felt confident enough to question what she seemed to feel was his mother's excuses for Martin's behaviour: "it's all because of his ADHD". She commented: "myself and his tutor are not too sure how much the ADHD is responsible for... I then find it really tricky to say, hang on no it's not, because I am not an expert." She repeated this a moment later:

*because I am not an expert at all these things, and I cannot always see that it's because of his condition, or that it's because he is an 11 year old boy. Some of it is an 11 year old boy thinking 'what can I get away with'. It is sometimes hard for me to say to mum, I cannot categorically say it is not his ADHD it is him being silly, because I am not in that position.*

Although she saw herself as 'not an expert' she also seemed to position herself as more authoritative than Martin's mother. She still found it 'tricky' and 'hard' to countermand his mother's view that it was the 'condition' causing the problem, not Martin himself. However what she could do instead was to create her own labels to make Martin small through discourse, repeatedly describing him as silly, or silly *and* little.

Other teachers also spoke about Martin in terms of labels and diagnosis, even when it was because they didn't understand them. In speaking generally about additional needs, one teacher said:

*But there's also diagnostic problems, I mean, I've got that boy Martin, now, he's ADHD and his parents think he's autistic, he's a Mormon, all I know is he's just miserable and puts his head on the table. I just don't get it. I mean, I think there's a lot of influences going on in his life. ...I don't know what the problem is.*

In observing his classes, it seemed clear that this teacher had a fraught relationship with some children. Martin's mother also described this, "he does find Martin very

frustrating apparently ... Martin finds him very, very difficult”. However the array of conditions and labels he assigned to Martin allowed him to ignore the effect that his own practice might be having. When asked if it would be helpful to know more about the children and what was going on for them, the teacher’s reply showed his anger at malfunctioning school systems (the individual education plan or IEP) and an unwillingness to engage with the idea of difference, while at the same time not being able to teach ‘as is’ either:

*Well, I could know the facts about him, but how would it affect me and how would it, how would it inform my practice? You know, if he’s ADHD, whatever that means, what’s that going to do for me? I’ve got some targets on IEP that are pretty derisory to be honest with you. I mean they’re pretty pretty derisory, pretty simplistic. How am I going to cope with an ADHD child, you know. He’s going to need special attention isn’t he, from someone, an ADHD worker with him, not me, who doesn’t know anything about ADHD. I’ve just got some guidelines in an IEP.*

The teacher *others* the child angrily, he was no longer a child to be taught like all the other children, “he’s ADHD, whatever that means”. His own anxiety and sense of helplessness in the face of all these new categories of need, “how am I going to cope”, was accentuated by his refusal to find out any more about either individual children or the categories themselves.

Martin himself didn’t want to be different, didn’t want to rely on medication to stop him from losing control, as he saw it.

*Martin: I hate taking them, I don’t like taking the medicines...*

*Researcher: Why’s that?*

*Martin: I just don’t like taking them, I just wanna be normal (sounding very disgruntled) I just...*

*Researcher: Oh, ok, yeah*

*Martin: But I’ve got to take tablets to make me feel better, otherwise I just lose control, because we tried it in primary school with the same thing, and at secondary school like, a day without and I just went ballistic. And that’s in a day.*

Later we talked again about ‘being normal’. This time Martin was able to say more about why he hated being ‘medicalised’ into normality; he wanted to be liked for the unaltered ‘him’ while being permitted to “do usual stuff”, to function as others do, an emotional plea for acceptance:

*Researcher: Normal’s a weird thing anyway, no one’s really normal*

*Martin: No, but I just want to, like, be...and like do usual stuff that other people do and be liked, and stuff... without... changing stuff*

In some school contexts, Martin was more able to relax and be himself. Here Martin was perceived as a different sort of little boy, not silly, or maliciously giggling as one teacher described him, ‘out of control’ or sitting outside the circle sulking, or miserable with his head on the table. Instead he was described as a ‘lovely lad’, an

‘absolute sweetie’. One of the school’s inclusion mentors described his participation in a new art group which was focusing on self-image:

*So Martin is with us in that group and he is just an absolute sweetie. He comes across as a really sweet little boy, I am just getting to know him so I haven’t seen any different but yeah lovely lad.*

Here there was no othering, no pushing him out or defining him by condition. Although he was again described as a ‘little boy’, this was not to insult him or make the adult feel more important, it portrayed a warm, empathic view of an eleven year old who wanted to be included and work with the group. Within the research data, this warmer expression of emotion towards children was most expressed by non-classroom staff at school, by health and social care staff, or in connection to a child eliciting sympathy through their family circumstances or obvious physical disability. It may be that for some professionals this boxing-off of warm emotions, of empathy, sympathy and connectedness, is a protection from emotional hurt where a situation is too complicated to understand easily, on top of the already strained day’s work. This defensive action stops them getting involved with children perceived as different, and allows them to judge in certain way. In a paper on the Victoria Climbié Inquiry Report, Andrew Cooper discusses the power of the fear of strongly uncomfortable emotion, which goes beyond simply affecting practitioners and their work. Cooper found that the protective instinct against painful emotion even colours the report itself (Cooper, 2005). Within education and other professions that we have seen here such as psychiatry, this defensive action may also stop some professionals from engaging beyond the surface with children perceived as different, allowing them to blame a condition, the child’s self, and sometimes their family, for discomfiting behaviour or ways of being. In doing this, they remove themselves from some of the emotional pain, but may inadvertently pass that same pain to the child instead.

## TRANSACTIONAL COMMUNICATION IN AN EMOTION-LADEN FIELD

To try and split off communication from other sorts of differentiating practices, such as diagnosis and emotive actions, should be untenable since it is implicitly and explicitly involved in interaction. The use of symbols to interact, whether those are signs of verbal communication – words and tone – or body language, can be through the internal interactions between the ‘I’ and the ‘Me’ which are based in intention and expectation (Outhwaite, 2005), or within the social world. In either event, communication should be about creating and *understanding* meaning, as a transaction rather than a way for one person (or side of the self) to impose information on the other: ‘this is to be understood as a transactional event in which structure and ambiguity, actuality and possibility, order and disorder are present. The temporality and teleology of the event cannot be safely ignored’ (Alexander, 1987:156, citing Dewey). Reder and Duncan have argued on several occasions that communication is at the crux of failures within integrated services, since it tends to be understood from

a position of logistics rather than internal processes: 'In particular, communication is an interpersonal process, so that its psychological and interactional dimensions must be addressed before practical measures can work effectively' (Reder & Duncan, 2003:84).

In Martin's case, communication, or the lack of it, created a situation where teachers insisted that Martin didn't listen to them, but Martin was equally adamant that he was not listened to either. His form tutor described his view of it:

*So what it comes down to with him is – and I've observed it – is that he will let himself get excited, and more and more excited, and more and more excited, and more and more wound up, and then someone shouts at him because he is ignoring, or, he's not ignoring but he's blinkered ...to what is going on, and they're saying 'sit down now Martin. Now please! Martin, please go and sit down'. Finally, you have to raise your voice, or, well you shouldn't really shout, but put on your steely voice, um, so that they know you mean business and then, um.. he sits down. But then he says 'oh that's not fair they didn't give me a chance, they shouted at me' because he hasn't heard the other tutor. When you have been asking him politely, which you shouldn't have to do because you are not supposed to run in class, end of story! but you've said: Martin please stop it Martin sit down.*

This narrative of Martin's deafness to instruction, full of shouting, raised voices, 'steely' voices, versus the politeness which the story ends with, tells one view of Martin's behaviour (and the teacher's of course). Martin felt differently about what happened: ignored, unacknowledged, unheard, unfairly treated.

*You talk to them, they don't listen to you? they don't acknowledge you, they don't do anything, they carry on talking to whoever they're talking to, or they carry on with whatever they were doing, and you ask them and ask them and then they go, they turn round and shout at you and give you a detention and you're like, just asked you a simple question and then they give you a detention straight away, it's just like, what? It's just... really weird.*

These two narratives, both telling gloomy and frustrated stories, teeter on the edge of a yawning gap of misunderstanding between the adult and the child. In many cases, it was the adult's voice that determined how others viewed a situation, despite some recognition that communication can be used as a tool to exclude unwanted children. Here, in discussing an incident involving another child in the research group who spent most of his time officially and unofficially excluded from the school, the SENCO described an example of this process:

*SENCO: if you don't want a child in your class, you can quite easily get them out, I mean like...*

*Researcher: Rules can be used?*

*SENCO: Not even rules, I think just the way you are with that kid, when they get to the door... You know, if Jimmy comes to your door a couple of minutes late swaggering about and you're like, get in here **now**, you're late, really rude to him and aggressive, he'll respond aggressively and it can be like,*

*right, red card, gone, it's easy isn't it. It's easy not to have Jimmy in your class, you don't have to, you can just wind him up in two seconds, or Danny... And I don't even think sometimes that's done consciously or deliberately, it's just a response you know, oh god, there's Jimmy, oh god there's Danny, they're stressed, they're nervous, is he going to wreck this lesson I sat up last night preparing and planning and those poor other kids that want to do it and...*

Although Martin did not provoke the same level of fear and anxiety in teachers that Jimmy and Danny did, he still felt that these unfair practices were used, sometimes by other children as well, creating an easy scapegoat of him so that teacher's authority could be restored:

*Martin: And then when the kids... tell, say, like, blame it on me the teacher believes them, instead of finding out they believe them and tell me off and give me a detention for it. And then, Mr P, you ask him a question, and he sends you out and then if umm... cause my friend X, at school he goes, um 'this stuff's boring sir', and so, so I said 'there's some interesting facts in there X!' and everyone starts laughing and then I got sent out for it! Cause I said it.  
Researcher: I expect you didn't think that was very fair  
Martin: No I didn't, no (sounding dismayed)*

While teacher training standards during the fieldwork stage of this research referred to the need for teachers to 'communicate effectively with children and young people within and beyond the classroom, in order to build rapport and secure learning and well-being' (TDA, 2008), these standards seemed often to only apply to those children who at some level adults did not fear. Just as the psychiatrist in this case seemed to allow her own 'depth emotion' to over-ride her ability to communicate effectively with Martin and his mother, many other children's service practitioners were creating anger, dismay, and confusion through transmitting their own uncomfortable emotions.

## CONCLUSION

Andrew Cooper wrote that the study of 'complex particulars' in practice-near research can provide the basis for a wider understanding of social problems:

The closer one comes to a single case, the more its uniqueness and particularity demands to be understood; but equally the more its value for the illumination of all other cases with which there is a family resemblance becomes evident. (Cooper, 2009: 432)

In considering the 'illogical', emotion-laden nature of interactions within this one child's case, this paper has begun to clarify an area which has a powerful affect on many children's outcomes. The emotions within responses influence person-to-person interaction and services provided – the actions around a child. Worries about improving outcomes for children are tempered by the fears and anxieties that

practitioners find difficult to manage while staying focused on the child: ‘At the level of both the particular case and the general responsibility, we know that terrible things are happening, but the pain of knowing is too great for us to be able to sustain our attention.’ (Cooper, 2005:10). It may be that those working on the perimeters of child welfare such as teachers, doctors, mental health workers or educational psychologists, those that Brandon *et al.* call ‘low participation’ in child protection (Brandon *et al.*, 2005: 164) are even less prepared to manage this pain of knowing than those with ‘high participation’ such as social workers. While the Munro Review of Child Protection (Munro, 2011) is clear that schools and others who work with children should be accountable for their well-being, in the field there is a gap between what is expected and direct practices with the child. One way forward here is to broaden perspectives of practitioner-reflection throughout education, health and social care, to ensure that it takes in more than technical, critical, and practical factors and includes process reflection as well (Ruch, 2007). When those in children’s services have the support and the will to do this, children will also have a better chance of receiving the support and relationships that they should have by right.

## REFERENCES

- Alexander, T.M. (1987) John Dewey’s Theory of Art, Experience & Nature: the Horizons of Feeling. State University of New York Press, New York.
- American Psychiatric Association. (2000) DSM-IV-TR: The Current Manual.
- Atkinson, P. & Housley, W. (2003) Interactionism: an essay in sociological amnesia. Sage, London.
- Audit Commission. (2008) Are we there yet? Improving governance and resource management in children’s trusts. Audit Commission, London.
- Axford, N. (2010) Is Social Exclusion a Useful Concept in Children’s Services? British Journal of Social Work, 40, 737–754.
- Billington, T. (2000) Separating, Losing and Excluding Children – Narratives of Difference. . RoutledgeFalmer, London.
- Blumer, H. (1969) Symbolic Interactionism - Perspective and Method. University of California Press, Berkeley.
- Brandon, M., Belderson, P., Warren, C., Gardner, R., Howe, D., Dodsworth, J. & Black, J. (2008) The Preoccupation with Thresholds in Cases of Child Death or Serious Injury through Abuse and Neglect Child Abuse Review, 17, 313-330.
- Brandon, M., Dodsworth, J. & Rumball, D. (2005) Serious Case Reviews: Learning to Use Expertise. Child Abuse Review, 14, 160-176.
- Chambon, A.S. (1999) Foucault’s Approach. In: Reading Foucault for Social Work. (eds A.S. Chambon, A. Irving & L. Epstein). Columbia University Press, New York.
- Charmaz, K. (2000) Grounded Theory: Objectivist and Constructivist Methods. In: Handbook of Qualitative Research (eds N. Denzin & Y. Lincoln). Sage, Thousand Oaks.
- Cooper, A. (2005) Surface and depth in the Victoria Climbié Inquiry Report. Child and Family Social Work, 10, 1-9.

- Cooper, A. & Lousada, J. (2005) *Borderline Welfare: feeling and fear of feeling in modern welfare*. Karnac, London.
- Denzin, N.K. (1984) *On Understanding Emotion*. Transaction, New Jersey.
- Department for Education and Skills. (2003) *Every Child Matters*. HM Government, London.
- Department for Education and Skills. (2004) *Every Child Matters: Changes for Children*. HM Government, London.
- Department for Education and Skills. (2006) *Multi-agency working - Glossary*.  
<http://www.everychildmatters.gov.uk/deliveringservices/multiagencyworking/glossary/>
- Department of Children Schools and Families. (2007) *ICS, CAF and ContactPoint - an overview*. [www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)
- Foucault, M. (1994) *Power*. Penguin Books, London
- Gold, R.L. (1958) Roles in Sociological Field Observations. *Social Forces*, 36, 217-223.
- HM Government. (1989) *Children Act 1989*. HMSO, London.
- Howe, D. (1996) Surface and depth in social-work practice. In: *Social Theory, Social Change and Social Work* (ed N. Parton), pp. 77-97. Routledge, London.
- Lord Laming. (2003) *The Victoria Climbié Inquiry: Summary and Recommendations*. HMSO.
- Marrable, T. (2011) *On needing 'need': an exploration of the construction of the child with 'additional needs'*. University of Sussex Doctoral Thesis, <http://sro.sussex.ac.uk/7440/>.
- Outhwaite, W. (2005) Interpretivism and Interactionism. In: *Modern Social Theory* (ed A. Harrington). Oxford University Press, Oxford.
- Reder, P. & Duncan, S. (2003) Understanding Communication in Child Protection Networks. *Child Abuse Review*, 12, 82-100.
- Reder, P. & Duncan, S. (2004) Making the Most of the Victoria Climbié Inquiry Report. *Child Abuse Review*, 13, 95-114.
- Rose, N. (1999) *Governing the Soul* Free Association Books, London.
- Rose, N. (2007) *The Politics of Life Itself*. Princeton University Press, New Jersey
- Taylor, C. (2004) Underpinning knowledge for child care practice: reconsidering child development theory. *Child & Family Social Work*, 9, 225-235.
- TDA. (2008) *QTS Standards Guidance: Q4*.
- Timimi, S. (2005) The Politics of Attention Deficit Hyperactivity Disorder (ADHD). In: *Critical Voices in Child and Adolescent Mental Health* (eds S. Timimi & B. Maitra). Free Association Books, London.
- Turney, D., Platt, D., Selwyn, J. & Farmer, E. (2011) *Social work assessment of children in need: what do we know? Messages from research*. DfE.
- Wearmouth, J. (1999) Another One Flew Over: 'Maladjusted' Jack's Perception of his Label. *British Journal of Special Education*, 26, 15-22.
- White, S. & Featherstone, B. (2005) Communicating misunderstandings: multi-agency work as social practice. *Child and Family Social Work*, 10, 207-216.
- Woodhead, M. (1997) Psychology and the Cultural Construction of Children's Needs. In: *Constructing and reconstructing childhood: contemporary issues in the sociological study of children* (eds A. James & A. Prout). Falmer Press, London:.